

# Health Questionnaire

1. In the PAST YEAR how often did you get acid reflux (a sour taste from acid rising up into your mouth or throat):

Never <input type="checkbox"/>	Less than once a month <input type="checkbox"/>	Less than once a week <input type="checkbox"/>	Once a week <input type="checkbox"/>	2-3 times a week <input type="checkbox"/>	4+ times a week <input type="checkbox"/>	Daily <input type="checkbox"/>
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2. In the PAST YEAR how often did you get heartburn? (a burning pain behind the breastbone after eating):

Never <input type="checkbox"/>	Less than once a month <input type="checkbox"/>	Less than once a week <input type="checkbox"/>	Once a week <input type="checkbox"/>	2-3 times a week <input type="checkbox"/>	4+ times a week <input type="checkbox"/>	Daily <input type="checkbox"/>
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3. Have you ever taken MEDICATION to treat heartburn or acid reflux?

No

Yes → Did you take any of the following medications?

	NO	YES →	Age you first had it?
1. Antacids e.g. Gaviscon, Quikeze, Rennie, Mylanta?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
2. Losec® or Zoton® or Acimax® or Maxor® or Probitor® or omeprazole?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
3. Nexium® or esomeprazole?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
4. Zoton® or lansoprazole?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
5. Somac® or pantoprazole?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
6. Pariet® or rabeprazole?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
7. Tazac® or nizatidine?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
8. Tagamet® or Cimehexal® or Magicul SPBA® or Sigmidine® or cimetidine?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
9. Zantac® or Ausran® or Rani® or Ranihexal® or Ranoxyl® or ranitidine?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
10. Pepzan® or Pepcid® or Pepcidine® or Pamicid® or famotidine?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
11. Maxolon® or metoclopramide?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
12. Prepulsid® or cisapride?	<input type="checkbox"/>	<input type="checkbox"/> →	years old
13. Other drugs for heartburn etc?	<i>please specify</i>		

4. Have you ever had a SURGICAL OPERATION to treat or prevent heartburn or acid reflux?

No

Yes → How old were you when you had surgery ?

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5. Have any members of your IMMEDIATE FAMILY (i.e. parents, siblings, children) ever been diagnosed with the following conditions. If YES, please circle all FAMILY MEMBERS affected :

Severe acid reflux / heartburn	<input type="checkbox"/>	<input type="checkbox"/> →	mother	father	brother	sister	son	daughter
Barrett's oesophagus	<input type="checkbox"/>	<input type="checkbox"/> →	mother	father	brother	sister	son	daughter
Oesophageal cancer	<input type="checkbox"/>	<input type="checkbox"/> →	mother	father	brother	sister	son	daughter

6. What is the MOST you ever weighed?

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kgs

OR

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st

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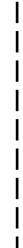
lbs

7. How often have you taken the following medications during the past 5 years?

<b>ASPIRIN</b> (eg. Aspro, Aspro-Clear, Disprin, Bex, Vincents, Alka-Seltzer)				
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Less than once a month	<input type="checkbox"/> 2-3 times a month	
<input type="checkbox"/> Once a week	<input type="checkbox"/> 2-3 times a week	<input type="checkbox"/> 4-7 times a week	<input type="checkbox"/> 2+ times a day	
<b>PARACETAMOL</b> (eg Panadol, Panamax, Tylenol, Dymadon)				
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Less than once a month	<input type="checkbox"/> 2-3 times a month	
<input type="checkbox"/> Once a week	<input type="checkbox"/> 2-3 times a week	<input type="checkbox"/> 4-7 times a week	<input type="checkbox"/> 2+ times a day	
<b>ANTI-INFLAMMATORY DRUGS</b> (eg Nurofen, Orudis, ACT3, Brufen, Rafen, Voltaren, Indocid, Naprosyn, Feldene, Arthrexin, Arthrotec, Actiprofen) <i>These drugs are usually taken for joint or muscle pain, headaches or period pain</i>				
<input type="checkbox"/> Never	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Less than once a month	<input type="checkbox"/> 2-3 times a month	
<input type="checkbox"/> Once a week	<input type="checkbox"/> 2-3 times a week	<input type="checkbox"/> 4-7 times a week	<input type="checkbox"/> 2+ times a day	

8. Have you smoked more than 100 cigarettes, cigars or pipes in your whole life?

No  Yes



(these next 3 questions are only for people who have ever smoked)

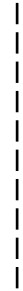
8A. At what age did you **START** smoking?   years

8B. Have you stopped smoking permanently?  
 N,  Y → At what age did you **STOP** smoking **PERMANENTLY**?   years

8C. How many cigarettes do (or did) you smoke on a **TYPICAL** day?

9. Have you ever consumed alcohol more often than once per month?

No  Yes



(these next 3 questions are only for people who have ever consumed alcohol)

9A. At what age did you **START** drinking?   years

9B. Have you stopped drinking permanently?  
 N,  Y → At what age did you **STOP** drinking **PERMANENTLY**?   years

9C. How many drinks do (or did) you have in a **TYPICAL** week? (tick the best answer below)

None	Less than 1	1	2-4	5-6	7-13	14-20	21-27	28 +
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Have you ever had any of these medical conditions?

	NO	YES →	Age you first had it?
Diabetes treated with insulin injections	<input type="checkbox"/> N	<input type="checkbox"/> Y →	<input type="text"/> <input type="text"/> years old
Diabetes treated with tablets and/or diet	<input type="checkbox"/> N	<input type="checkbox"/> Y →	<input type="text"/> <input type="text"/> years old
High blood pressure treated with tablets	<input type="checkbox"/> N	<input type="checkbox"/> Y →	<input type="text"/> <input type="text"/> years old
Stomach cancer	<input type="checkbox"/> N	<input type="checkbox"/> Y →	<input type="text"/> <input type="text"/> years old
Oesophageal cancer	<input type="checkbox"/> N	<input type="checkbox"/> Y →	<input type="text"/> <input type="text"/> years old

11. Have you completed any further study since leaving school? (Please mark box)

No  Technical/College diploma  Trade certificate/apprenticeship  University degree

Other

*Office use only* Date   /   / 20

Height    Weight    Waist